UNIVERSITY of DEBRECEN

HEALTH QUESTIONNAIRE

Personal information

Name (as in passport):	
Given Name(s):	
Family Name (Surname):	
Date and place of birth (dd/mm/yyyy, city, country):	
Nationality:	
Permanent address:	
Gender:	
E-mail/Phone number:	
Next of Kin (Emergency Contact) phone number:	

Past medical history

Please describe the disease(s) that you have ever had before.

Have you ever received hospital care? If yes, please specify (date, diagnosis etc.).

Chronic conditions, illnesses (Please choose. If yes, provide details.)

Question	No / Yes	Details
Do you require regular medical care for any reason?	☐ No / ☐ Yes	
Are you on regular medication?	☐ No / ☐ Yes	
Do you have any allergies?	☐ No / ☐ Yes	
Have you ever experienced loss of consciousness?	☐ No / ☐ Yes	
Do you have any mental health condition or disorder?	☐ No / ☐ Yes	
Do you have any dermatological condition?	☐ No / ☐ Yes	
Do you have any disabilities or special needs?	☐ No / ☐ Yes	
Do you have any visual, hearing, cognitive, physical, mobility, learning, or other impairment?	☐ No / ☐ Yes	

I hereby confirm that I have provided all information to the best of my knowledge regarding my health condition, and that these details are true and accurate.

Furthermore, I confirm that I will report any infectious or other serious (non-infectious) diseases that may arise during my university studies to the competent healthcare service.

Debrecen, ...

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signature